MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(46-F)

9359

Reg. Dist. No. 333

1. PLACE OF DEATH:
County Wicomico
City or town Fruitland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 62 Years
Hospital, Institution, or street address where death occurred: Fruitland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD County Wicomico
City or town Furitland
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Thomas Henry Adkins

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary S. Adkins
6.(c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): June 22, 1883

8. AGE: Years	Months	Days	If less than one day
62	2	9	hrs. min.

9. Birthplace: Wicomico, Co. Md. (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business

FATHER
12. Name: George Adkins
13. Birthplace: Wicomico Co. Md.

MOTHER
14. Maiden name: Not Know
15. Birthplace

16. Informant: Mrs Thoms H. Adkins
Address: Fruitland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/4/45 (month) (day) (year)
Cemetery or crematory: Shad Pointn Cemetery
Location: Shad Point, MD.

18. Funeral director: The Hill & Johnson Co,
Address: Salisbury, MD.

19. 9/13, 1945 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 1, 1945, at 1120a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 20 1945, to Sept 1 1945
and that I last saw h alive on Sept 1 1945

Immediate cause of death	DURATION
Coronary Occlusion	7 D
Due to Cancer of Gall Bladder	2 yr
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Henson.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

9360

Reg. Diat. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 30 years

Hospital, Institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 1 day 5 hrs 40 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Salisbury Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: na

(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: Austin, Samuel

3.(b) Social Security Number: na

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Lucile Austen

Dead 6.(c) If alive, give age: na years

7. Birth date of deceased (mo., day, yr.): about 70 years 1875

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
about 70	—	—		

9. Birthplace: Hebron md (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Saw mill

FATHER — 12. Name: Henry Austin

13. Birthplace: Hebron Md

MOTHER — 14. Maiden name: Mary Austin

15. Birthplace: Salisbury Md

16. Informant: Lucy Roach

Address: Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 6 1945 (month) (day) (year)

Cemetery or crematory: Houston

Location: Salisbury Md

18. Funeral director: James H. Stewart

Address: Salisbury Md

19. 9/15 (Date rec'd by registrar) 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 2, 1945 at 5:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 31 1945, to Sept 1 1945

and that I last saw h[illegible] alive on Sept 1 1945

Immediate cause of death	DURATION
Acute Pulmonary Edema	
Due to: Hypertensive Cardio-Vascular Disease Congestive Heart failure	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. Rivers Hanson, M.D. M. D. or other

Address: Salisbury, Md Date signed 9-3-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

19361

Reg. Diat. No. 337

1. PLACE OF DEATH:

County: Worcester

City or town: Mantiocke (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Worcester

City or town: Mantiocke (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Thomas E. Bankings

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col	Widower

6.(b) Name of husband or wife: Matilda Bankings

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): about 1860

8. AGE: Years	Months	Days	If less than one day
about 85	Dont		..... hrs. ..... min.

9. Birthplace: Mantiocke Md (Town, county, and state)

10. Usual occupation: Oyster man

11. Industry or business

FATHER — 12. Name: Dont Know

FATHER — 13. Birthplace: " "

MOTHER — 14. Maiden name: Dont Know

MOTHER — 15. Birthplace: " "

16. Informant: John Jones

Address: Mantiocke

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/5/45 (month) (day) (year)

Cemetery or crematory: Mantiocke Md

Location: Near Jester's Store

18. Funeral director: C. E. Messick

Address: Girdle Md

19. Sept 4 (Date rec'd by registrar) 1945 R. Woolford Walter Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9/2/45, 19..., at 1.50 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-30-45 to 9-2-45, 19..., and that I last saw him alive on 8-2-45, 19...

Immediate cause of death	DURATION
Coronary Thrombosis	12 hrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: D. Allen Wells M. D. or other

Address: Mantiocke Md Date signed 9-3-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Wanner

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

9362

★ Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 days
Hospital, institution, or street Address where death occurred: P.B. Hosp.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 119 Dover Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Gary Lynn Beasley

3. (b) Social Security Number:

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced:
6.(b) Name of husband or wife:
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Aug. 19-1945
8. AGE: Years | Months | Days: 15 | If less than one day: ..... hrs. ..... min.
9. Birthplace: P.B. Hosp. Salisbury Md.
(Town, county, and state)
10. Usual occupation:
11. Industry or business:
FATHER 12. Name: George C. Beasley
13. Birthplace: Princess Anne Md.
MOTHER 14. Maiden name: Mildred Louise Littleton
15. Birthplace: Delmar Md.
16. Informant: Mr. George C. Beasley
Address: 119 Dover St. Salisbury Md
17. Buried (Burial, cremation, or removal. Which?) Date thereof: Sept 5-45 (month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury Md.
18. Funeral director: Hollowy & Co. Walter R. Hollowy
Address: Salisbury Md.
19. 9/6 1945 Harriet C. Johnson Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 3rd 1945 at 8-17 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 29 1945 to Sept 3 1945 and that I last saw him alive on Sept 3 1945

	DURATION
Immediate cause of death: Ritters Disease	5 days
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ..... Injured at work?

23. SIGNATURE: Wanner M.D.
M. D. or other
Address: Salisbury Date signed: Sept 4 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

C9363

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

Reg. Diat. No. 933

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? about 25 years
Hospital, Institution, or street address where death occurred:
Peninsula General Hospital
How long in hospital or institution? about 2 weeks 3 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Wicomico
City or town: Salisbury Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 102 Jenkins St
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: Rosa Bishop

3.(b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	a a	Married

6.(b) Name of husband or wife: Waysman Bishop Dan'l Bruce
6.(c) If alive, give age: yes years

7. Birth date of deceased (mo., day, yr.): about 1882

8. AGE: Years: about 63 | Months: — | Days: — | If less than one day: ... hrs. ... min.

9. Birthplace: Parsonsburg Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER — 12. Name: Nathanial Rhodes
13. Birthplace: Parsonsburg md

MOTHER — 14. Maiden name: Harriett Timmons
15. Birthplace: Parsonsburg md

16. Informant: Waysman Bishop
Address: Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 25 1945 (month) (day) (year)
Cemetery or crematory: Glen Hill
Location: Parsonsburg md

18. Funeral director: James H. Stewart
Address: Salisbury md

19. 9/25/45 (Date rec'd by registrar) Louise D. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept - 20 19 45 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/2 19 45, to 9/20 19 45
and that I last saw h alive on 9/20 19 45

Immediate cause of death	DURATION
Acute Pulmonary Edema	
Due to Gangrene Rt. Lower Extremities	
Due to Hypertensive Cardiovascular Disease	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op.
Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Rivers Hanson M.D.
M. D. or other
Address: Salisbury, Md. Date signed 9/22/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

09364

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

Reg. Dist. No. 939

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Wicomico

City or town Salisbury Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Eliza Kathryn Burch

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	widow

6.(b) Name of husband or wife Daniel T. Burch

B.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 2, 1864

8. AGE:

Years	Months	Days	If less than one day
81	6	17	hrs. min.

9. Birthplace Worcester Co. Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Joseph Hall

13. Birthplace Md.

MOTHER 14. Maiden name Mary Lewis

15. Birthplace Md.

16. Informant Kathryn Williams

Address Salisbury, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 21, 1945 (month) (day) (year)

Cemetery or crematory Evergreen Cemetery

Location Berlin, Md.

18. Funeral director Marguerite T. Watson

Address Pocomoke City, Md.

19. 9/19/45 (Date rec'd by registrar) 19 Lafayette C. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 19 19 45 at 2:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 44 to Sept 19 19 45 and that I last saw h.. alive on Sept 18 19 45

	DURATION
Immediate cause of death Coronary Thrombosis	2 yrs
Due to	
Due to	
Other conditions Valvular Heart Disease, Hypertension	Years Years

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Homer R. Mann M. D. or other

Address Salisbury Md. Date signed 9/19/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

CERTIFICATE OF DEATH

9365

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury (If ontside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 hrs
Hospital, Institution, or street address where death occurred: P. G. Hospital
How long in hospital or institution? 6 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md County: Wicomico
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No.: 3625 Fairview ave (If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Vanita K. Conall

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 23 1930

8. AGE: Years: 15 Months: 2 Days: 15 If less than one day: hrs. min.

9. Birthplace: Atlantic City N. J. (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: Norman S. Conall
13. Birthplace: Pittsburg, Pa.

MOTHER
14. Maiden name: Frances Marshant
15. Birthplace: Balto. md

16. Informant: Donald A. Miller 3625 Fairview ave Balto md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/1/41 (month) (day) (year)
Cemetery or crematory: Lorraine Cemetery
Location: Baltimore, md

18. Funeral director: Hill & Johnson co
Address: Salisbury, md

19. 9/2/41 (Date rec'd by registrar) Harriet F. Thomas Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 2 1941, at 5 24 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..., to ..... 19.....
and that I last saw h... alive on ..... 19.....

	DURATION
Immediate cause of death: Fractures Skull	6 hrs.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of Sept 1 '41
Where did injury occur? Snow Hill Worcester Md (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Highway
Means of injury: struck by car Injured at work? No

23. SIGNATURE: John L. Riley D.P.M. M. D. or other
Address: Snow Hill Md Date signed: Sept 2 41

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09366

Reg. Dist. No. 327

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Wicomico

City or town Jesterville, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Jesterville
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Catherine C Conway

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	Col.	Married

6.(b) Name of husband or wife George Conway

6.(c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) July 27 1907

8. AGE:

Years	Months	Days	If less than one day
38	2		hrs. min.

9. Birthplace Nanticoke, Md.
(Town, cooty, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Marcellus Nuttle
13. Birthplace Nanticoke, Md.

MOTHER
14. Maiden name Ida Nuttle
15. Birthplace Nanticoke

16. Informant George Conway
Address Jesterville, Md.

17. Burial Date thereof 10/1/45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cemetery

Location Nanticoke, Md.

18. Funeral director E. A. Pressick

Address Girdletree Md

19. Sep. 29 1945 R. Mallard Nuttle
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-27 1945, at 1250 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-15 1945, to 9-27 1945 and that I last saw h alive on 9-15-45 1945

Immediate cause of death	DURATION
Massive Cerebral Hemorrhage	
Due to Hypertension	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. T. Pressell M. D.
M. D. or other

Address 600 W Main St Date signed 9-29-45

COPY SENT TO Co. Health Officer DATE 10/4/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47)

CERTIFICATE OF DEATH

19367

Reg. Diat. No. 233

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days
Hospital, institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Pocomoke City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 604 Cedar Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME Preston Cottman

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Pauline Cottman
6.(c) If alive, give age: 19 years

7. Birth date of deceased (mo., day, yr.): April 28, 1923

8. AGE: Years	Months	Days	If less than one day
22	4	28	hrs. min.

9. Birthplace: RURAL, Pocomoke, Somerset Cnty, Md.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Farm

FATHER
12. Name: Unknown
13. Birthplace: "

MOTHER
14. Maiden name: Emma Cottman
15. Birthplace: Washington, D.C.

16. Informant: Emma Cottman
Address: 604 Cedar St. Pocomoke City Md.

17. (Burial, cremation, or removal. Which?) Burial Date thereof: Sept. 23 1945 (month) (day) (year)
Cemetery or crematory: Tinley's Chapel Cemetery
Location: Pocomoke City #Rt. 1 Md
18. Funeral director: H. Harvey Bradshaw
Address: Pocomoke City Md.

19. Sept. 23, 1945 (Date received by registrar) Harriet E. Johnson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 19 1945, at 3 a. m. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ——— 19—— to ——— 19——
and that I last saw h— alive on ——— 19——

Immediate cause of death	DURATION
Stab wound in stomach	4 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: homicide Date of: Sept 19
Where did injury occur? Pocomoke City Worcester Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Public street
Means of injury: Stab Injured at work? no

23. SIGNATURE: John L. Riley Dep Asst Exam M. D. or other
Address: Pocomoke City Md. Date signed: 9/19/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

69368

★ Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Eden, Md. Rural 2

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

At home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Wicomico

City or town Eden, Md. Rural 2

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Azriah Franklin Cox

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Lucy Cox

6.(c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1854

8. AGE: Years	Months	Days	If less than one day
91	7	5	..... hrs. ..... min.

9. Birthplace Wicomico, Co. MD. (Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business

FATHER 12. Name Thomas Cox

13. Birthplace VA.

MOTHER 14. Maiden name Ella Ingersoll

15. Birthplace Wicomico. co. Md.

16. Informant Mrs Lucy Cox

Address Eden, Md. Rural 2

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9 / 9 / 45 (month) (day) (year)

Cemetery or crematory Siloam Cemetery

Location Siloam, Md.

18. Funeral director The Hill & Johnson Co.

Address Salisbury, Md.

19. 9/9 (Date rec'd by registrar) 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 7 1945, at 10 50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 1945, to Sept 7 1945 and that I last saw h... alive on Sept 1 1945

Immediate cause of death	DURATION
Acute Valv. Heart	7 hrs
Due to Chr. Int Nephr.	2 yrs
Due to Arter. Sclerosis	2 yrs
Other conditions Dropsy	2 yrs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W D Davis M D M. D. or other

Address Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Nock.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4

CERTIFICATE OF DEATH

9369

★ Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 days

Hospital, Institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Virginia County Accomack

City or town Chincoteague Va (If outside city or town limits, write RURAL and give nearest town)

Street No. — (If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Mrs. Virginia Dorsey

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

8.(b) Name of husband or wife Elmer Dorsey

8.(c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) NOV 4 1888

8. AGE:	Years	Months	Days	If less than one day
	56	9	28	— hrs. — min.

9. Birthplace Chincoteague Virginia (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business —

FATHER — 12. Name Joshua Williams

13. Birthplace Chincoteague Va

MOTHER — 14. Maiden name Drucilla Shockley

15. Birthplace Chincoteague Virginia

16. Informant Edna Shields Hove

Address Chincoteague Va

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 4 1945 (month) (day) (year)

Cemetery or ~~Cemetery~~ Mechanics Chincoteague Va

Location Chincoteague Virginia

18. Funeral director Walter M. Lelo Jr.

Address 953 Main Chincoteague Va

19. 9/21/45 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 1 1945 at 3 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19— to Sept 1 1945 and that I last saw her alive on Aug 1 1945

Immediate cause of death	DURATION
Impacted Gallbladder	
Due to	
Due to	
Other conditions Heedless Smoking	

(Include pregnancy within 3 months of death)

Major findings of operations Dead

Date of op. May 30, 1945

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other

Address Salisbury Maryland Date signed 9-19-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

09370

CERTIFICATE OF DEATH

Reg. Dist. No. 933

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury Md (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: na
How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Del. County: Sussex
City or town: Laurel Del (If outside city or town limits, write RURAL and give nearest town)
Street No. no (If rural, give LOCATION)
2.(a) If veteran, name war: no ✓

3. (a) FULL NAME: Shannon Dashiell

3. (b) Social Security Number: Dont know

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	a.a.	married

6.(b) Name of husband or wife: Blanche Dashiell
6.(c) If alive, give age: yes Dont know years
7. Birth date of deceased (mo., day, yr.): about 1904

8. AGE: Years	Months	Days	If less than one day
41 about			hrs. min.

9. Birthplace: Salisbury (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Same as above
FATHER 12. Name: Beth Dashiell
FATHER 13. Birthplace: Salisbury md
MOTHER 14. Maiden name: Lula Parsons
MOTHER 15. Birthplace: Salisbury md
16. Informant: Lonnie Dyland
Address: Laurel Del
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 4-1945 (month) (day) (year)
Cemetery or crematory: Laurel
Location: Laurel Del
18. Funeral director: James B. Elward
Address: Salisbury md
19. 10/4 1945 Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9-29 1945 at ? M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Accidental drowning	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 9-29-45.
Where did injury occur? Salisbury Md. (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Public place
Means of injury Drowning. Injured at work?

23. SIGNATURE: Lloyd A. Timmons M.D. M. D. or other
Address: Salisbury Md Date signed 9-30-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; the ... is especially important. Physicians: please write the causes of death clearly and legibly.

09371

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (184)

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH: Wicomico
County
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 years 11 mo. 28 d.
Hospital, institution, or street address where death occurred P. G. Hospt.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 310 Anne street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Robert Lee Day
3. (b) Social Security Number

4. Sex Male
5. Color or race White
6.(a) Single, married, widowed, or divorced
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) Oct. 2nd 1938
8. AGE: Years 6 Months 11 Days 28 If less than one day ... hrs. ... min.
9. Birthplace Salisbury Maryland
(Town, county, and state)
10. Usual occupation School Boy
11. Industry or business

FATHER
12. Name Robert Day
13. Birthplace Salisbury Maryland

MOTHER
14. Maiden name Martha J. Martin
15. Birthplace Eden Maryland

16. Informant Mrs. Martha J. Day
Address 310 Anne st Salisbury Md
17. Burial (Burial, cremation, or removal? Which?) Date thereof Oct. 2-45 (month) (day) (year)
Cemetery or crematory Parsons Cem.
Location Salisbury Maryland
18. Funeral director Holloway & Co. Walter R. Holloway
Address Salisbury Md.
19. 10/2/45 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29th 1945, at 6 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 29 1945 to Sept 29 1945
and that I last saw him alive on Sept 29 1945
Immediate cause of death Bullet wound in Brain — DURATION
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations none
Date of op.
Autopsy results none
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 9/29/45
Where did injury occur? Salisbury, Wicomico, Md. (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) at home
Means of injury Bullet wound injured at work?
23. SIGNATURE R. Hanson, M.D. M. D. or other
Address Salisbury, Md. Date signed 10/1/45

Evidence for addition of age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

G98 SEP 21 1945

CERTIFICATE OF DEATH

9372

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Wicomico

City or town Tyaskin

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Thomas Dickerson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	married

6.(b) Name of husband or wife Sarah Dickerson

6.(c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) -------

8. AGE:

Years	Months	Days	If less than one day
47			....hrs. ....min.

9. Birthplace Tyaskin, Md. (Town, county, and state)

10. Usual occupation Farming

11. Industry or business

FATHER 12. Name Levi Dickerson

13. Birthplace Tyaskin, Md.

MOTHER 14. Maiden name Doit known.

15. Birthplace

16. Informant Rebecca Dickerson

Address Tyaskin, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/5/45 (month) (day) (year)

Cemetery or crematory cemetery

Location Tyaskin Colored Church

18. Funeral director C. A. Messick

Address Bivalve, Md.

19. 9/6 1945 (Date rec'd by registrar) Laura E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/2/1945 at 11 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ....19.... to ....19....

and that I last saw him alive on ....19....

Immediate cause of death	DURATION
Due to Coronary Thrombosis	Sudden death
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. A. Robertson M.D. Deputy Med Examiner M. D. or other

Address Salisbury Md. Date signed 9/5/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-2)

CERTIFICATE OF DEATH ★

(9373

Reg. Dist. No. 23

1. PLACE OF DEATH:

County Wicomico

City or town Hebron (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 43 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Wicomico

City or town Hebron (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Samuel Edward Downing

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married

6.(b) Name of husband or wife Mrs. Mary Downing

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 5th 1875

8. AGE: Years 70 | Months 2 | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Green Hill, Wicomico, Md. (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Minos Downing

13. Birthplace Green Hill Md.

MOTHER 14. Maiden name Amanda Taylor

15. Birthplace Green Hill, Md.

16. Informant Mrs. Mary Downing

Address Delmar Md.

17. Burial (Burial, cremation, or removal? Which?) Date thereof 9/29/45 (month) (day) (year)

Cemetery or crematory Hebron Cemetery

Location Hebron, Md.

18. Funeral director David L. Messick

Address Hebron Md.

19. Sept 29 1945 (Date rec'd by registrar) Mrs J. M. Walter Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 26, 1945 at 10:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1945 to Sept 26 1945 and that I last saw h[illegible] alive on Sept 26 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage Embolism	3 days
Due to Chronic Myocarditis & nephritis	8 yrs.
Due to Enlarged Prostate	4 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE [signature] M. D. or other

Address Delmar Date signed Sept 28 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(9374)

Reg. Dist. No. 323

1. PLACE OF DEATH: Wicomico

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: P.H. Hospt.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Willards

(If outside city or town limits, write RURAL and give nearest town)

Street No. R.D. #1.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mildred Catherine Faulow

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Ernest F. Faulow

6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): Dec. 23. 1901

8. AGE: Years	Months	Days	If less than one day
43	9	2	....hrs. ....min.

9. Birthplace: Salisbury Maryland (Town, county, and state)

10. Usual occupation: Home wife

11. Industry or business: at Home

FATHER

12. Name: Larry W. Cordrey

13. Birthplace: Sussex Co. Del.

MOTHER

14. Maiden name: Mary M. Maddox

15. Birthplace: R.D. Delmar - Del.

16. Informant: Mr. Ernest F. Faulow

Address: R.D. #1. Willards Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Sept. 28-45 (month) (day) (year)

Cemetery or crematory: Pine Church Cem.

Location: R.D. Pittsville, Maryland

18. Funeral director: Holloway & Wallace H. Holloway

Address: Salisbury Maryland.

19. 9/28/45 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 25 19 45 at 6.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 15 19 45, to Sept 25 19 45 and that I last saw h... alive on Sept 25 19 45

Immediate cause of death	DURATION
(a) Ca. of Pancreas	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ✓ Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ✓ Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C. H. Gus M. D. or other

Address: Salisbury Date signed: 9/26/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

9375

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury Md (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred: no

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Wicomico

City or town: Salisbury Md (If outside city or town limits, write RURAL and give nearest town)

Street No. 516 W. Isabella (If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: Henry L. Hazzett

3.(b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	A. C.	Married

6.(b) Name of husband or wife: Minnie L. Hazzett

6.(c) If alive, give age: Yes years

7. Birth date of deceased (mo., day, yr.): about 1873

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
about 72	—	—		

9. Birthplace: Canada (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Farm

FATHER — 12. Name: L. Houghton Hazzett

FATHER — 13. Birthplace: Berlin Md

MOTHER — 14. Maiden name: Caroline A. Hawkins

MOTHER — 15. Birthplace: Canada

16. Informant: Mrs. Minnie L. Hazzett

Address: Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 7, 1945 (month) (day) (year)

Cemetery or crematory: Parsons Cemetery

Location: Salisbury Md

18. Funeral director: James F. Stewart

Address: Salisbury Md

19. 9/7/45 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9/2/1945 at 9:30 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19.. to ..... 19.. and that I last saw h.. alive on ..... 19..

	DURATION
Immediate cause of death: Suffocation due to Burns of body	sudden death
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.:

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of 9/2/45

Where did injury occur? Salisbury (City or town) Wicomico (County) Md (State)

Injured at home, farm, industry, public place (where?): Home

Means of injury: Clothing caught fire while lighting lamp Injured at work? No

23. SIGNATURE: [illegible] M.D. or other

Address: Salisbury Md Date signed: 9/7/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92)

CERTIFICATE OF DEATH

69576

Reg. Dist. No. 393

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 25 years

Hospital, institution, or street address where death occurred: no

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: md County: Wicomico

City or town: Salisbury md
(If outside city or town limits, write RURAL and give nearest town)

Street No.: no
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3. (a) FULL NAME: Howard Fields

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	a. a.	unmarried

6.(b) Name of husband or wife: no

6.(c) If alive, give age: no years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: Amount of age Incorrect | Months | Days | If less than one day: hrs. min.

9. Birthplace: Dames Quarter (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Farm

FATHER
12. Name: Elzey Fields
13. Birthplace: Dames Quarter, Maryland

MOTHER
14. Maiden name: Annie White
15. Birthplace: Dames Quarter, Maryland

16. Informant: Washington Fields

Address: Dames Quarter, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 3 1945 (month) (day) (year)

Cemetery or crematory: Dames Quarter md

Location: Dames Quarter md

18. Funeral director: James F. Stewart

Address: 402 E. Church St. Salisbury Md

19. 9/8/1945 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 1 1945, at 6 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 1945 to Sept 1 1945 and that I last saw him alive on Sept 1 1945

Immediate cause of death	DURATION
Chronic Interstitial Heart Disease	yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. Wroner M D M. D. or other

Address: Salisbury Date signed: 9/8/1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

09377

★ Reg. Dist. No. 223

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 Years
Hospital, institution, or street address where death occurred:
John B. Parsons Home
How long in hospital or institution? 15 Years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.: John B. Parsons Home
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Hannah Garrett

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 20, 1864

8. AGE: Years	Months	Days	If less than one day
81	6	30	hrs. min.

9. Birthplace: Kent, Co. Md. (Town, county, and state)
10. Usual occupation: None
11. Industry or business
FATHER 12. Name: William C. Garrett
13. Birthplace: Maryland
MOTHER 14. Maiden name: Amanda V. Dowling
15. Birthplace: Kent Co. Md.
16. Informant: Supt. John B. Parson Home
Address: Salisbury, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/22/45 (month) (day) (year)
Cemetery or crematory: Chester Cemetery
Location: Chestertown, Md.
18. Funeral director: The Hill & Johnson Co.
Address: Salisbury, Md.
19. 9/22, 1945 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 19 19 45 at 630a p M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 15 19 45 to Sept 19 19 45
and that I last saw ~~her~~ alive on Sept 18 19 45

Immediate cause of death	DURATION
Valvular Heart Disease	Years
Due to	
Due to	
Other conditions: Chronic Nephritis, Hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Hunter R. Marvel M. D. or other
Address: Salisbury Md. Date signed: 9/20/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

19378

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, Institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Somerset

City or town Princess Anne Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Charles W. Griffith

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Ruth Griffith

6.(c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) August 15, 1902

8. AGE: Years	Months	Days	If less than one day
43	0	19	...hrs. ...min.

9. Birthplace Frostburg, Md. (Town, county, and state)

10. Usual occupation Merchant

11. Industry or business

FATHER — 12. Name David W. Griffith

13. Birthplace Frostburg, Md.

MOTHER — 14. Maiden name Cora Richardson

15. Birthplace Frostburg, Md.

16. Informant Ruth Griffith

Address Princess Anne, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 6, 1945 (month) (day) (year)

Cemetery or crematory Frostburg Cemetery

Location Frostburg, Md.

18. Funeral director Dale W. Ashell

Address Princess Anne Md.

19. 9/11/45 (Date rec'd by registrar) Maggie E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-3 1945 at 11:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-3 1945 to 9-3 1945 and that I last saw h... alive on 9-3 1945

Immediate cause of death	DURATION
Acute gangrenous pancreatitis	24 hrs
Due to	
Due to	
Other conditions none	

(Include pregnancy within 3 months of death)

Major findings of operations none ...Date of op.

Autopsy results acute pancreatitis - changes of pancreas

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following; No

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Lee Rademaker M.D.

M. D. or other

Address Salisbury Md Date signed 9/11/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

19379

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 45 years
Hospital, institution, or street address where death occurred: P.H. Hospt.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.D. #3 (If rural, give LOCATION) Ocean City Road
2.(a) If veteran, name war:

3.(a) FULL NAME: Lawrence Roe Hastings

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary I. Hastings
6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): Jan. 13-1862

8. AGE: Years: 73 | Months: 10 | Days: 8 | If less than one day: ... hrs. ... min.

9. Birthplace: R.D. Princess Anne Md (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business:

FATHER
12. Name: Daniel H. Hasting
13. Birthplace: Pocomoke Md

MOTHER
14. Maiden name: Amber Eden Payne
15. Birthplace: Pittsville Md.

16. Informant: Mrs. Preston Jones
Address: R.D. #1. Berlin Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Sept. 24-45 (month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury Md.

18. Funeral director: Hillman & Walter R. Hillman
Address: Salisbury Md.

19. 9/24/45 (Date rec'd by registrar) Roscoe E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 21st 1945 at 8 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 29 1945, to Sept 21 1945, and that I last saw him alive on Sept 20 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [illegible] M. D. or other
Address: Salisbury, Md. Date signed: 9/23/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09380

Reg. Dist. No. 327

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Worcester

City or town: Pocomoke

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 75 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Nanticoke

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Annie May Heath

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb 11 1877

8. AGE: Years: 68 | Months: 8 | Days: 13 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Nanticoke (Town, county, and state)

10. Usual occupation: House Keeping

11. Industry or business

FATHER — 12. Name: Lewis F. Heath

FATHER — 13. Birthplace: Nanticoke

MOTHER — 14. Maiden name: Ella D. Heath

MOTHER — 15. Birthplace: Nanticoke

16. Informant: Nellie Painter

Address: Tangier Island, Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/27/45 (month) (day) (year)

Cemetery or crematory: Tawes Cem. Nanticoke Md.

Location: Nanticoke, Md.

18. Funeral director: Geo. Fitzgerald

Address: Nanticoke Md.

19. 9/27 1945 (Date rec'd by registrar) R. Woolford Waller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 24 1945, at 8:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15 1945 to Sept 24 1945 and that I last saw h... alive on Sept 23, 45 1945

Immediate cause of death	DURATION
Due to: Apoplexy	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: D. Allen Fields M. D. or other

Address ..... Date signed .....

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

69381

Reg. Diat. No. 233

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 days

Hospital, Institution, or street address where death occurred: P. H. Hospital

How long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Mardela
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Luke Johnson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W.	Married

6.(b) Name of husband or wife: Sallie Johnson

6.(c) If alive, give age: 38 years

7. Birth date of deceased (mo., day, yr.): Feb. 25, 1902

8. AGE:

Years	Months	Days	If less than one day
43	6	29	hrs. min.

9. Birthplace: Seaford, Sussex, Md.
(Town, county, and state)

10. Usual occupation: Farming

11. Industry or business:

FATHER
12. Name: M. A. Johnson
13. Birthplace: Elkridge, Md.

MOTHER
14. Maiden name: Annie B. Shockley
15. Birthplace: Mardela Md.

16. Informant: Mrs. Sallie Johnson
Address: Mardela Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/26/45 (month) (day) (year)

Cemetery or crematory: Mardela Cem.

Location: Mardela, Md.

18. Funeral director: David L. Messick

Address: Hebron Md.

19. 9/26/45 (Date received by registrar) Harriet G. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 24 1945 at 8:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 15 1945 to Sept 24 1945 and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Carcinoma of Pancreas	70 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: S Allen Fields M. D. or other

Address: Salisbury, Md. Date signed 9-25-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09382

CERTIFICATE OF DEATH

Reg. Diat. No. 933

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Berlin R. F. D.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Kellam Mrs. Katherine

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married.

6.(b) Name of husband or wife: William T. Kellam

6.(c) If alive, give age: 27 years

7. Birth date of deceased (mo., day, yr.): May 17, 1917

8. AGE:	Years	Months	Days	If less than one day
	28	3	27	....hrs. ....min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Housewife.

11. Industry or business

FATHER — 12. Name: William Bryant.

FATHER — 13. Birthplace: Virginia

MOTHER — 14. Maiden name: Lula Murray

MOTHER — 15. Birthplace: Virginia

16. Informant: Mrs. William Bryant.

Address: Berlin Md R F D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/19/45 (month) (day) (year)

Cemetery or crematory: Mt. Hadley.

Location: Onancock, Va.

18. Funeral director: Mrs. Bessie A. Burbage

Address: Berlin Md.

19. 9/17 (Date rec'd by registrar) 19 46 Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9-14 1945 at 12 05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-3 1945 to 9/14 1945 and that I last saw her alive on 9-13 1945

Immediate cause of death	DURATION
Pelvic retroperitoneal cellulitis	8 weeks
Due to: Infected abortion	67 days
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Cellulitis left Retroperitoneal area — Date of op. 9/11/45

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. A. Rademaker M.D.
M. D. or other

Address: Salisbury Md. Date signed 9/14/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

69383

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 327

1. PLACE OF DEATH:
County Wicomico
City or town Tyaskin
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 yrs.
Hospital, Institution, or street address where death occurred
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Tyaskin
(If outside city or town limits, write RURAL and give nearest town)
Street No. L
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Bertha J. Fairmore

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married.

6.(b) Name of husband or wife Geo. W. L. Fairmore
6.(c) If alive, give age 77 years
7. Birth date of deceased (mo., day, yr.) March 3-1871

8. AGE: Years	Months	Days	If less than one day
74	6	12	hrs. min.

9. Birthplace Berlin Md. (Town, county, and state)
10. Usual occupation Home wife
11. Industry or business

FATHER
12. Name George C. Horman
13. Birthplace Berlin Md.

MOTHER
14. Maiden name Julia Mariniger
15. Birthplace Clara Md

18. Informant Mr. Geo. W. L. Fairmore
Address Tyaskin Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 18-45 (month) (day) (year)
Cemetery or crematory Parsons Cem.
Location Salisbury Maryland
18. Funeral director Wilson & C. Walter R. Holloway
Address Salisbury Md.
19. Sep 18 1945 R. Wailford Walter Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 15th 1945 at 1. P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 17th 1945 to September 15th 1945 and that I last saw h alive on September 15th 1945

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to	
Due to	
Other conditions Chronic Nephritis	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE William Emrich M. D. or other
Address Helen Md Date signed Sept 17th 45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(1) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

69384

CERTIFICATE OF DEATH

★ Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 Years

Hospital, institution, or street address where death occurred: 418 Smith ST

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Salisbury

(If outside city of town limits, write RURAL and give nearest town)

Street No. 418 Smith ST.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Margaret V. Laws

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Lee Laws

6.(c) If alive, give age: 82 years

7. Birth date of deceased (mo., day, yr.): Dec. 29, 1871

8. AGE: Years	Months	Days	If less than one day
73	8	10	....hrs. ....min.

9. Birthplace: Whiton, Wicomico, CO. MD

(Town, county, and state)

10. Usual occupation: At Home

11. Industry or business

FATHER — 12. Name: Adam P. Bethard

13. Birthplace: Worcester Co, Md.

MOTHER — 14. Maiden name: Isabelle Burbage

15. Birthplace: Worcester, Co. Md.

16. Informant: L. Lee Laws

Address: Salisbury, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/ 11/ 45 (month) (day) (year)

Cemetery or crematory: Parsons Cemetery

Location: Salisbury, MD.

18. Funeral director: The Hill & Johnson Co.

Address: Salisbury, Md.

19. 9/11/45 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 9 19 45 at 11.25 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 15 19 45, to Sept 9 19 45, and that I last saw h alive on Sept 9 19 45

Immediate cause of death: Apoplexy — DURATION: 20 days

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: D Allen Fields M. D. or other

Address: Salisbury, Md. Date signed: 9/11/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83(a)

CERTIFICATE OF DEATH

09385

Reg. Dist. No. 333

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury
(If ontside city or town limits, write RURAL and give nearest town)
How long in above place of death? 33 years
Hospital, institution, or street address where death occurred: 312 Charles St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 411. Martin, S.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Sarah Elizabeth Lokey

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	White	Widow

B.(b) Name of husband or wife John W. Lokey
6.(c) If alive, give age ... years Dead

7. Birth date of deceased (mo., day, yr.) Aug 15 1870

8. AGE: Years 75 | Months 1 | Days 8 | If less than one day ... hrs. ... min.

9. Birthplace Whaleyville Md.
(Town, county, and state)

10. Usual occupation Home W[illegible]

11. Industry or business At Home

FATHER
12. Name William Mitchell
13. Birthplace Ireland

MOTHER
14. Maiden name Martha E. Carey
15. Birthplace Selbyville Del.

16. Informant Mrs. Walter Lindy
Address 312 Charles St. Salisbury Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof Sept. 26-45 (Month) (day) (year)
Cemetery or crematory Parsons Cem.
Location Salisbury Md
18. Funeral director Holloway & Co. Walter R. Holloway
Address Salisbury Md.

19. 9/26/45 (Date rec'd by registrar) Harriet A. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 23-45 at 7.40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1945 to Sept 23 1945 and that I last saw h[illegible] alive on Sept 23 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	12 hours
with grave Bronchitis	
Due to Hypertension and arteriosclerosis	5 yrs
Due to Acute articular rheumatism	2 wks
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [illegible] M.D.
Address Salisbury Md Date signed Sept 26/45

M. D. or other

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157)

CERTIFICATE OF DEATH

9386

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Peninsula Gen. Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Wicomico

City or town Ocean City

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Lovell, Baby Boy #1

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) SEPT 11, 1945

8. AGE: Years	Months	Days	If less than one day
		3	..... hrs. ..... min.

9. Birthplace Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name Mitchell Lovell

13. Birthplace Newark N.J.

MOTHER — 14. Maiden name Grace Wallbetter

15. Birthplace Philadelphia Penna

16. Informant Mr. Mitchell Lovell

Address Newark N. J.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/17/45 (month) (day) (year)

Cemetery or crematory Evergreen

Location Berlin Md

18. Funeral director Burna B. Burbage

Address Berlin Md.

19. 9/17, 1945 (Date rec'd by registrar) Hassie E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 14, 1945, at 10:50 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 11, 1945 to Sept 14, 1945

and that I last saw h. IM alive on Sept 14, 1945

Immediate cause of death	DURATION
Prematurity	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Harry A. Lowe M. D. or other

Address Salisbury, Md Date signed 9-16-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09387

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: ~~Peninsula Hotel~~ Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years
Hospital, institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution? about 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Wicomico
City or town: Near Salisbury and
(If outside city or town limits, write RURAL and give nearest town)
Street No.: no
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: John W Manakey

3.(b) Social Security Number: Don't know

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	A.A.	married

6.(b) Name of husband or wife: Ida Manakey
6.(c) If alive, give age: ~~don't know~~ years
7. Birth date of deceased (mo., day, yr.): about 1886

8. AGE: Years	Months	Days	If less than one day
about 59	—	—	..... hrs. ..... min.

9. Birthplace: Maryland Anne Arundel Co.
(Town, county, and state)
10. Usual occupation: Minister
11. Industry or business: Same as above
MOTHER FATHER
12. Name: unknown
13. Birthplace: unknown
MOTHER
14. Maiden name: unknown
15. Birthplace: unknown
16. Informant: Mrs Ida Manakey
Address: New York City
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 30th 1945 (month) (day) (year)
Cemetery or crematory: Payne
Location: Washington D.C.
18. Funeral director: James H. Stewart
Address: Salisbury Md
19. 9/29/45 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 26 19.... at 5-00 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 18 19.4.. to Sept 25 19.45
and that I last saw h.. alive on Sept 24 19.45

Immediate cause of death	DURATION
Apoplexy	12 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: .....
Date of op.: .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of: .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work? .....

23. SIGNATURE: D. Allen Field M. D. or other
Address: Salisbury Md Date signed: 9-26-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (467)

09388

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution? 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED
(For newborn infants give residence of mother)
State: Md County: Wic
City or town: Sharptown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Charles Marine

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Edna Marine
6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): Oct 19 1879

8. AGE: Years: 65 | Months: 11 | Days: 20 | If less than one day: hrs. min.

9. Birthplace: Sharptown Wic Md (Town, county, and state)

10. Usual occupation: Ship Carpenter

11. Industry or business:

FATHER
12. Name: James F. Marine
13. Birthplace: Md

MOTHER
14. Maiden name: Julia Robinson
15. Birthplace: Md

16. Informant: Edna Marine
Address: Sharptown, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 9 (month) 9 (day) 1945 (year)
Cemetery or crematory: Fairmount
Location: Sharptown
18. Funeral director: Graylemp Bros
Address: Sharptown Md.

19. 9/9 (Date rec'd by registrar) 19 46 Harriet E. Shockley (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 7, 1945, at 12.40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 22 1945 to September 7, 1945
and that I last saw him alive on 9-7-45 1945

Immediate cause of death	DURATION
Carcinoma of Head of Pancreas	3 -
Due to:	
Due to:	
Other conditions: Uremia -	1 week

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma - Head of Pancreas
Date of op. Aug 28.45
Autopsy results: None.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Lee L. Lowry M.D.
M. D. or other
Address: Salisbury Md. Date signed 9.7.45.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

09389

CERTIFICATE OF DEATH

Reg. Dist. No. 923

1. PLACE OF DEATH:
County: Salisbury Wicomico
City or town: (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 years
Hospital, institution, or street address where death occurred: 413 Davis Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
Street No. 413 Davis St (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Annie C. Morris

3.(b) Social Security Number:

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widow
6.(b) Name of husband or wife: James A. Morris
6.(c) If alive, give age: Dead years
7. Birth date of deceased (mo., day, yr.): Feb. 16-1870
8. AGE: Years 75 Months 7 Days It less than one day hrs. min.
9. Birthplace: R.D. Willard Md. (Town, county, and state)
10. Usual occupation:
11. Industry or business: At Home

FATHER
12. Name: Millbourne Layton
13. Birthplace: Wicomico Co. Md.

MOTHER
14. Maiden name: Charlotte Lewis
15. Birthplace: Willards Md.

16. Informant: Mrs. Ella Hammond
Address: R.D. #3 Salisbury Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 19-1945 (month) (day) (year)
Cemetery or crematory: Hammond Cem. Near Salisbury Md.
Location:
18. Funeral director: Wallace & Walter R. Wallace
Address: Salisbury Maryland.
19. 9/19/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 16th 1945, at 4:15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 14 1945, to Sept 16 1945
and that I last saw h.. alive on June 14 1945

Immediate cause of death	DURATION
Cerebro-vascular	
Cue to: renal disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Thos. A. Smith M. D. or other
Address: Salisbury Md. Date signed 9-18-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170c)

CERTIFICATE OF DEATH

09390

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 days

Hospital, Institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Talbot

City or town: Easton

(If outside city or town limits, write RURAL and give nearest town)

Street No. 203 Earl St.

(If rural, give LOCATION)

2.(a) If veteran, name war: V

3. (a) FULL NAME: Mumper, Mayme

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single.

B.(b) Name of husband or wife:

B.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 7, 1880

8. AGE: Years: 64 Months: 9 Days: If less than one day: hrs. min.

9. Birthplace: York, Pa. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER 12. Name: Michael John Mumper

13. Birthplace: Dillsburg, Pa

MOTHER 14. Maiden name: Ruth Ann Trout

15. Birthplace: Ohio

16. Informant: Mrs. Edw. Kastenhuber

Address: Easton, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Sept. 12 1945 (month) (day) (year)

Cemetery or crematory: Prospect Hill Cemetery

Location: York, Pa.

18. Funeral director: John D. Williams

Address: Easton, Md.

19. 9/11 (Date received by registrar) 1945 Harriet C. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 7 1945 at 11:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19... and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death: General peritonitis	12 days
Due to: Ruptured Caecum Traumatic	12 hrs
Due to:	
Other conditions: Laceration 1 nose Bruise of Rt Knee	12 days

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of: 9-26-1945

Where did injury occur? Hebron (City or town) Wicomico (County) Md (State)

Injured at home, farm, industry, public place (where?): Highway

Means of injury: Car struck pole Injured at work? No

23. SIGNATURE: Ja Rademaker MD Henry Med Examiner

M. D. or other

Address: Salisbury Md Date signed: 9/8/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2 (a)

09391

CERTIFICATE OF DEATH ★

Reg. Dist. No. 332

1. PLACE OF DEATH:
County: Wicomico
City or town: Pittsville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Pittsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Fred V. Parker

3. (b) Social Security Number •

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Flora Parker
LIVING 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 16 1867

8. AGE: Years	Months	Days	If less than one day
78	3	16	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business

FATHER
12. Name: Minos Parker
13. Birthplace: Maryland

MOTHER
14. Maiden name: Charlotte Brittingham
15. Birthplace: Maryland

16. Informant: Mrs. Mattie Bratten
Address: Parsonsburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 8 1945 (month) (day) (year)
Cemetery or crematory: Parker Cemetery
Location: Pittsville, Maryland.

18. Funeral director: W. W. Howard Wells
Address: Pittsville, Md.

19. Sept. 6 1945 (Date rec'd by registrar) Lillian R. Davis Registrar Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 6th 1945 at 9.20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-1-45 19 to day of death and that I last saw him alive on 9-6-45 19

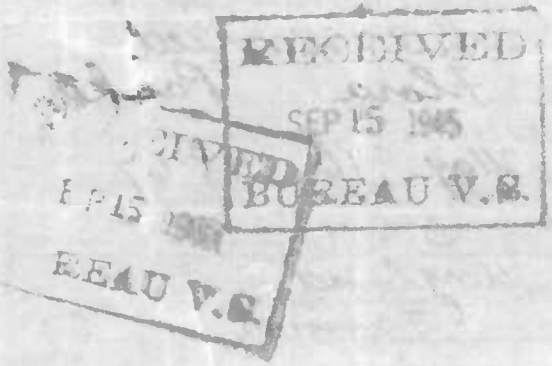
Immediate cause of death	DURATION
Infectious Dysentery	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Frank K. Lewis M.D.
M. D. or other
Address: Pocomoke Md. Date signed 9-7-45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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

09392

CERTIFICATE OF DEATH

Reg. Diat. No. 393

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7/28
Hospital, Institution, or street address where death occurred:
Peninsula General Hospital
How long in hospital or institution? 2 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Lake Street
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3. (a) FULL NAME: Robert Price

3. (b) Social Security Number: 220-10-8335

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	a a	married

6.(b) Name of husband or wife: Pauline Price
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): About 45 yrs. 1900

8. AGE: Years	Months	Days	If less than one day
About 45			..... hrs. ..... min.

9. Birthplace: Chance, Maryland (Town, county, and state)
10. Usual occupation: Chef
11. Industry or business: English Grill

FATHER
12. Name: Rome Wright
13. Birthplace: Chance, Maryland

MOTHER
14. Maiden name: Ira Beckett
15. Birthplace: Chance, Maryland

16. Informant: Mrs. Lillian Conway
Address: 25 Houston St. Salisbury, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-8-45 (month) (day) (year)
Cemetery or crematory: Houston Cemetery
Location: Salisbury, Maryland

18. Funeral director: James F. Stewart
Address: 402 E. Church St. Salisbury Md.

19. 9/8 (Date rec'd by registrar) 19 45 Laura E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9-4 19 45 at 9 05 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-19 19 45, to 9-4 19 45 and that I last saw h. alive on 9-4 19 45

Immediate cause of death	DURATION
advanced Cardiac renal failure	6 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.:
Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. A. Rademaker M.D. M. D. or other
Address: Salisbury, Md. Date signed: 9/16/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09393

CERTIFICATE OF DEATH

Reg. Diat. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 days.
Hospital, institution, or street address where death occurred: The Peninsula General Hospital
How long in hospital or institution? 15 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. Delaware County: Sussex
City or town: Selbyville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1702.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War #2. ✓

3.(a) FULL NAME Lloyd Quillen

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Jan. 24, 1916

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
29	7	30		

9. Birthplace: Ocean City, Md. (Town, county, and state)
10. Usual occupation: ~~Laborer~~ U.S. Army
11. Industry or business: Soldier

FATHER
12. Name: Charles B. Quillen
13. Birthplace: Md.

MOTHER
14. Maiden name: Clara Hudson
15. Birthplace: Md.

16. Informant: Mrs. Mae Quillen
Address: Selbyville, Del.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 25, 1945 (month) (day) (year)
Cemetery or crematory: Odd
Location: Bishopville, Md.
18. Funeral director: M. Pasha Watson
Address: Selbyville, Del.

19. 9/26/45 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9-23-45 19... at 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-8-45 19... to 9-23-45 19... and that I last saw him alive on 9-23-45 19...

Immediate cause of death	DURATION
Gastritis - Tuberculous -	2yrs.
Enteritis - Tuberculous -	
Due to: Tuberculosis - Pulmonary -	3yrs.
Due to:	
Other conditions: Cachexia — Severe -	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.: —
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: L. L. Lowry M.D.
M. D. or other
Address: Salisbury, Md. Date signed: 9-24-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

09394

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years
Hospital, institution, or street address where death occurred: P.G. Hospt.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
Street No.: 702 Camden, Ave. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Rosa Lee Ralph
3.(b) Social Security Number

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Charles W. Ralph
6.(c) If alive, give age: 61 years
7. Birth date of deceased (mo., day, yr.): Oct. 21-1885

8. AGE: Years 59 | Months 11 | Days 4 | If less than one day ... hrs. ... min.

9. Birthplace (Town, county, and state): R.D. Salisbury, Md.
10. Usual occupation: House wife
11. Industry or business: at Home
FATHER 12. Name: Purtory Ellingsworth
13. Birthplace: R.D. Salisbury, Md.
MOTHER 14. Maiden name: Annie Byrd
15. Birthplace: R.D. Salisbury Md.
16. Informant: Mr. Charles W. Ralph
Address: 702. Camden ave. Salisbury Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 20-1945 (month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury, Maryland
18. Funeral director: Holloway Co. Walter R. Holloway
Address: Salisbury Md.
19. 9/20, 19 45 (Date rec'd by registrar) Hassie E. Johnson, Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 17th 1945, at 7.15 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 31 1945, to Sept 17 1945
and that I last saw her alive on Sept 17 1945

	DURATION
Immediate cause of death: Coronary Thrombosis	Sudden death
Due to	
Due to	
Other conditions: Fractured spine-ribs wrists (Include pregnancy within 3 months of death)	17 days

Major findings of operations: None
Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident. Date of: Aug 31, 1945
Where did injury occur? Salisbury (City or town) Wicomico (County) Md. (State)
Injured at home, farm, industry, public place (where?): Home
Means of injury: fell over railing. Injured at work? No
23. SIGNATURE: J A Kallenwaker, Deputy med Examiner, M. D. or other
Address: J A Kallenwaker MD. Date signed 9/17/45

09395

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-0)

CERTIFICATE OF DEATH

Reg. Diat. No. 339

1. PLACE OF DEATH:

County: Wicomico;

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45 Years

Hospital, institution, or street address where death occurred:

416 Camden Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: MD County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No. 416 Camden; Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Nettie P. Renshaw

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: George E. Renshaw

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 12, 1873

8. AGE: Years	Months	Days	If less than one day
72	7		..... hrs. ..... min.

9. Birthplace: Wicomico, Co, MD.

(Town, county, and state)

10. Usual occupation: At Home

11. Industry or business

FATHER — 12. Name: Theodore Gosle[illegible]

FATHER — 13. Birthplace: Wicomico, Co, Md.

MOTHER — 14. Maiden name: Martha E. Malone

MOTHER — 15. Birthplace: Wicomico, Co. Md.

16. Informant: H. Franklin Renshaw

Address: Salisbury, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/13/45 (month) (day) (year)

Cemetery or crematory: Allen Cemetery

Location: Allen, MD.

18. Funeral director: The Hill[illegible] Johnson Co

Address: Salisbury, MD.

19. 9/13/45 (Date rec'd by registrar) Carroll E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept, 11 1945 at 7 am M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1940 to 9/11 1945 and that I last saw h[illegible] alive on 9/11 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	Instant.
Due to) Hypertensive Cardio-Vascular Disease	5 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. Rivers Hanson M.D.

M. D. or other

Address: Salisbury, Md Date signed 9/13/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09396

Reg. Dist. No. 933

1. PLACE OF DEATH:
County: Wisomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 60 years
Hospital, Institution, or street address where death occurred:
Anderson Rd. & Grantuex
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Wisomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Anderson Rd. & Grantuex Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Elizabeth E. Richardson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Sewell H Richardson
6.(c) If alive, give age ← years

7. Birth date of deceased (mo., day, yr.): Oct 24 1863

8. AGE: Years	Months	Days	If less than one day
81	10	11	hrs. min.

9. Birthplace: Worcester Co. Md
(Town, county, and state)
10. Usual occupation: at Home
11. Industry or business
FATHER 12. Name: Joshua H Morris
13. Birthplace: Worcester Co. Md
MOTHER 14. Maiden name
15. Birthplace
16. Informant: Vaughn M. Richardson
Address: Salisbury Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/8/45 (month) (day) (year)
Cemetery or crematory: Parsons cemetery
Location: Salisbury Md
18. Funeral director: The Hall & Johnson Co
Address: Salisbury Md
19. 9/8 (Date rec'd by registrar) 19 45 Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 6, 1945, at 6:45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 5 1945 Sept 6 1945
and that I last saw h... alive on Sept 5 1945

Immediate cause of death	DURATION
Valvular Heart Disease	Unknown
Due to	
Due to	
Other conditions: Secondary Anemia	Unk

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Henry R Mayo M. D.
Address: Salisbury Md Date signed 9/9/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09697

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years
Hospital, Institution, or street address where death occurred: 1405 E. Church, street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
Street No. 1405 E. Church St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Wilmer Crockett Roberts

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Cornelia Augusta Roberts
6.(c) If alive, give age: 26 years

7. Birth date of deceased (mo., day, yr.): Oct. 2nd 1915

8. AGE:

Years	Months	Days	If less than one day
29	11	5	...hrs. ...min.

9. Birthplace: Clara Maryland (Town, county, and state)
10. Usual occupation: Insurance Salesman
11. Industry or business: Life Insurance

FATHER
12. Name: Russel Roberts
13. Birthplace: Clara Md.

MOTHER
14. Maiden name: Emma Crockett
15. Birthplace: R.D. Fruitland Maryland

16. Informant: Mrs. Cornelia Augusta Roberts
Address: 1405 E. Church St. Salisbury Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Sept 10-1945 (month) (day) (year)
Cemetery or crematory: Wico. Mem. Park,
Location: Salisbury Maryland
18. Funeral director: Holloway & Walter R. Holloway
Address: Salisbury Md.

19. 9/10/45 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 7th 1945 at 11.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 15 1945 to Sept 7 1945 and that I last saw him alive on Sept 7 1945

Immediate cause of death	DURATION
(a) Uremia Pneumonia	3 wks
Due to (b)	
Due to (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Warrenner M.D.
M. D. or other
Address: Salisbury Md. Date signed: Sept 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

09398

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (153)

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Peninsula General Hospital

How long in hospital or institution? 6 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Delaware County Sussex

City or town Seaford - Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Baby Girl Ruf

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife —

8.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) September 21, 1945

8. AGE:

Years	Months	Days	If less than one day
—	—	—	6 hrs. — min.

9. Birthplace Salisbury Maryland
(Town, county, and state)

10. Usual occupation Infant

11. Industry or business —

FATHER
12. Name Herbert Ruf
13. Birthplace Dorchester County, Maryland

MOTHER
14. Maiden name Elma O'Bier
15. Birthplace Sussex County, Delaware

16. Informant Herbert Ruf
Address Seaford, Delaware, R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof September 22 1945 (month) (day) (year)

Cemetery or crematory Bethel Cemetery

Location Near Federalsburg Maryland

18. Funeral director J. J. Frampton & Son

Address Federalsburg, Maryland

19. 9/22, 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 22 1945, at 4:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 21 1945, to Sept 22 1945

and that I last saw her alive on Sept 22 1945

Immediate cause of death Congenital debility — DURATION 9/21/45

Due to — DURATION

Due to — DURATION

Other conditions — DURATION

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M.D.
M. D. or other

Address Bridgeville, Del. Date signed 9/22/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

09399

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

★ Reg. Diat. No. 999

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 Years

Hospital, Institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution? 1 Day

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Wicomico

City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)

Street No. 705 Salisbury Blvd. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Henry A. Ryder

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Gertrude C. Ryder

6.(c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) March, 24, 1881

8. AGE: Years	Months	Days	If less than one day
64	5	26	...hrs. ...min.

9. Birthplace York, Penna. (Town, county, and state)

10. Usual occupation Pharmaceutical Dortor

11. Industry or business

FATHER 12. Name Henry H. Ryder

13. Birthplace Livepool, England

MOTHER 14. Maiden name Lavenia Hale

15. Birthplace Baltimore, Md.

16. Informant Mrs Henry A. Ryder

Address Salisbury, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/24/45 (month) (day) (year)

Cemetery or crematory Lorraine Cemetery

Location Baltimore, Md.

18. Funeral director The Hill & Johnson Co.

Address Salisbury, Md

19. 9/22/45 (Date rec'd by registrar) Hazel E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 20, 1945 at 7.30 p M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 16 1945 to Sept 20 1945 and that I last saw him alive on Sept 19 1945

Immediate cause of death	DURATION
Coronary Thrombosis	3 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ...Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Swanner M.D. M. D. or other

Address Salisbury Md. Date signed 9/22/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

(19430)

Reg. Diat. No. 329

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution? about 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: md County: Wicomico
City or town: Salisbury md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 115 Dilaware St
(If rural, give LOCATION)
2.(a) If veteran, name war: md

3.(a) FULL NAME Samuell D. Stafield

3.(b) Social Security Number Don't know

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	a.a.	married

6.(b) Name of husband or wife: Ida Stafield
6.(c) If alive, give age: yes Don't know years

7. Birth date of deceased (mo., day, yr.): about 1889

8. AGE: Years 56 | Months — | Days — | If less than one day ... hrs. ... min.

9. Birthplace: Pocomoke md (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Farmer

MOTHER FATHER
12. Name: John Stafield
13. Birthplace: Pocomoke
MOTHER
14. Maiden name: Susan Baston
15. Birthplace: Pocomoke md

16. Informant: Mrs Ida Stafield
Address: Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 14-1946 (month) (day) (year)
Cemetery or crematory: Trinity
Location: Pocomoke md

18. Funeral director: James A. Stewart
Address: Salisbury md

19. 10/1 1946 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 10, 1946 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 18 1945 to Sept 10 1946
and that I last saw h... alive on Sept 10 1946

Immediate cause of death	DURATION
Cardio vascular	
Due to: Renal Insuf	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Thos A Linthicum M. D. or other
Address: Salisbury md Date signed: Sept 14 1946

09491

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (57)

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Worcester
City or town Berlinsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Twin #1 Selby

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Infant

6.(b) Name of husband or wife —
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 1 1945

8. AGE: Years | Months | Days | If less than one day: 1 hrs. ..... min.

9. Birthplace Salisbury Wic. Md
(Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER
12. Name Everett Selby
13. Birthplace Bishopville Md

MOTHER
14. Maiden name Edna Murray
15. Birthplace Selbyville, Del.

16. Informant Everett Selby
Address Bishopville Md RFD

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 2 1945 (month) (day) (year)
Cemetery or crematory Red Mem
Location Selbyville Del

16. Funeral director M. Pasha Watson
Address Selbyville Del

19. 9/2/45 (Date rec'd by registrar) Harriet S. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-1-45 19 ..... at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from birth to death 19 ..... to ..... 19 .....
and that I last saw him alive on 9-1-45 19 .....

Immediate cause of death	DURATION
Live birth	
was 5 month pregnancy	
premature development	
Due to and shock	
Due to Hyaline membrane	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations .....
Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Grant P. Lewis M.D.
M. D. or other
Address Pittsville Md Date signed 9-2-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr Lewis
M
C

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

09402

CERTIFICATE OF DEATH

Reg. Dist. No. 233

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Bishopville (If outside city or town limits, write RURAL and give nearest town)

Street No. — (If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Twin #2 Selby

3.(b) Social Security Number

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Infant

6.(b) Name of husband or wife —

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Sept 1 1945

8. AGE: Years / Months / Days / If less than one day ... hrs. ... min.

9. Birthplace: Salisbury Wic, Md (Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER 12. Name: Everett Selby

13. Birthplace: Bishopville Md

MOTHER 14. Maiden name: Edna Murray

15. Birthplace: Selbyville Del

16. Informant: Everett Selby

Address: Bishop Md R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 2 1945 (month) (day) (year)

Cemetery or crematory: Red Men

Location: Selbyville Del

18. Funeral director: M Pasha Watson

Address: Selbyville Del

19. 9/2, 1945 (Date rec'd by registrar) Harriet E Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-1-45 19... at ... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from birth to death, 19... to ... 19...

and that I last saw him alive on 9-1-45 19...

Immediate cause of death: Premature development and "shock" (5 months)

Due to: Hydramnios

Due to:

Other conditions (Include pregnancy within 3 months of death)

DURATION

Major findings of operations ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE: Frank J Lewis M.D. (M. D. or other)

Address: Willards Md Date signed: 9-2-45

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

094 [illegible]

Reg. Dist. No. 233

1. PLACE OF DEATH

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years

Hospital, Institution, or street address where death occurred: R.D. #3

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No.: R.D. #3

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Peter Sidney Smack

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Sallie E. Smack

6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): June 1st 1870

8. AGE:

Years	Months	Days	If less than one day
75	3	8	...hrs. ...min.

9. Birthplace: Worcester Co. Md. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER — 12. Name: Joshua Smack

FATHER — 13. Birthplace: Worcester Co. Md.

MOTHER — 14. Maiden name: Sallie Wilkins

MOTHER — 15. Birthplace: Worcester Co. Md

16. Informant: Mrs. Sallie E. Smack

Address: R.D. #3 Salisbury Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 12-45 (month) (day) (year)

Cemetery or crematory: St. Johns Epis.

Location: Powellville Md.

18. Funeral director: Holloway & Co. Walter R. Holloway

Address: Salisbury Md.

19. 9/12/45 (Date rec'd by registrar) Harriet E. Johnson (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 9th 1945 at 8.45 P.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from ...19... to ...19..., and that I last saw h... alive on ...19...

Immediate cause of death	DURATION
Coronary thrombosis	Sudden death
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.:

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Jos. Trademaker M.D. Deputy Med Examiner. M. D. or other

Address: Salisbury, Md. Date signed: 9/9/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

09404

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:
County: Wicomico
City or town: Pittsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Pittsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Allison T. W. Smith

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Annie J. Smith
6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): Sept. 1 - 1880

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
65	—	13		

8. Birthplace: Wicomico Co. Md.
(Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business

FATHER
12. Name: Taylor Smith
13. Birthplace: Wicomico Co. Md.

MOTHER
14. Maiden name: Martha Driscoll
15. Birthplace: Wicomico Co. Md.

16. Informant: Mrs. Annie J. Smith
Address: Pittsville Maryland

17. (Burial, cremation, or removal? Which?) Buried Date thereof (month) (day) (year) Sept. 16-45
Cemetery or crematory: Pittsville Cem.
Location: Pittsville Maryland

18. Funeral director: Holloway & Co. Walter R. Holloway
Address: Salisbury Maryland

19. (Date rec'd by registrar) Sept. 16 1945 Lillian R. Davis Registrar
Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 14 1945 at 12:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 30 1945 to Sept. 14 1945 and that I last saw him alive on Sept. 13, 1945

Immediate cause of death	DURATION
Chronic myocarditis.	
Pulmonary T.B.	2 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ✓ Date of —
Where did injury occur? (City or town) (County) (State) ✓
Injured at home, farm, Industry, public place (where?)
Means of injury ✓ Injured at work? ✓

23. SIGNATURE: Grant T. Leavitt M.D.
M. D. or other
Address: Willards Md. Date signed 9-14-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Wimmer

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186a)

09405

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 years
Hospital, institution, or street address where death occurred: 1211. E. Railroad, ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md County Wicomico
City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)
Street No. 1211. E. Railroad ave. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Ida Belle Smith

3.(b) Social Security Number

4. Sex Female
5. Color or race White
6.(a) Single, married, widowed, or divorced Widow
6.(b) Name of husband or wife John H. Smith
6.(c) If alive, give age Dead years
7. Birth date of deceased (mo., day, yr.) Sept. 12 - 1873

8. AGE: Years 71 Months 11 Days 26 If less than one day ....hrs. ....min.

9. Birthplace near Walston Md. (Town, county, and state)
10. Usual occupation House wife
11. Industry or business at Home
FATHER 12. Name George Perdue
13. Birthplace R.D. Parsonsburg, Md
MOTHER 14. Maiden name Sarah Ann Driscoll
15. Birthplace R.D. Parsonsburg Md.
16. Informant M. Trowbridge Smith
Address 1211. E. Railroad, ave., Salisbury Md
17. Burial (Burial, cremation, or removal, Which?) Date thereof Sept. 11 - 1945 (month) (day) (year)
Cemetery or crematory Parsons Cem.
Location Salisbury Md.
18. Funeral director Holloway & Co. Walter R. Holloway
Address Salisbury Md.
19. 9/11, 1945 Harriet E. Johnson (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8th 1945, at 7:30 a M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 1945, to Sept 8 1945
and that I last saw her alive on Sept 7 1945

Immediate cause of death Fracture pelvis — DURATION 1 wk

Due to Accidental fall — fell down stairs At her home, on Railroad Avenue C.W.G.R.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Accident Date of About 9-1-1945
Where did injury occur? Salisbury (City or town) Wicomico (County) Maryland (State)
Injured at home, farm, industry, public place (where?) At home
Means of injury Accidental fall. Injured at work?

23. SIGNATURE J. Wimmer M.D. M. D. or other
Address Salisbury Date signed Sept 7

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

09496

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 332

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Wicomico

City or town: Pittsville R.F.D. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 mos

Hospital, institution, or street address where death occurred: —

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Willards (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Elizabeth P. Stephenson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

8.(b) Name of husband or wife: John T. Stephenson — 8.(c) If elsewhere, give age: years

7. Birth date of deceased (mo., day, yr.): Dec 25, 1871

8. AGE: Years: 73 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Willards (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Housework

FATHER — 12. Name: Wesley Stephenson

13. Birthplace: Md.

MOTHER — 14. Maiden name: Sallie Unknown

15. Birthplace: Md.

16. Informant: G. Muncie Stephenson

Address: Pittsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 18, 1945 (month) (day) (year)

Cemetery or crematory: Friendship

Location: Pittsville Md.

18. Funeral director: Mr. Pasha Watson

Address: Salisbury, Md.

19. Sept. 18, 1945 (Date rec'd by registrar) Lillian T. Davis, Registrar, Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 16, 1945, at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1st, 1945, to Day of Death and that I last saw h[illegible] alive on 9-15-45, 1945

Immediate cause of death: Myocarditis (Chronic)

Due to: Diabetes mellitus.

Due to:

Other conditions: Arthritis

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Frank R Lewis M.D. M. D. or other

Address: Willards Md. Date signed: 9/16/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

09407

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Fruitland Md (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life about 6 hours

Hospital, institution, or street address where death occurred: no

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Fruitland Md (If outside city or town limits, write RURAL and give nearest town)

Street No.: no (If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: Thomas Douglas Stewart

3.(b) Social Security Number: no

4. Sex: male

5. Color or race: a. a.

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife: no

6.(c) If alive, give age: no years

7. Birth date of deceased (mo., day, yr.):

8. AGE: Years — Months — Days — If less than one day: about 9 hrs. 15 min.

9. Birthplace: Fruitland md (Town, county, and state)

10. Usual occupation: no

11. Industry or business: no

FATHER 12. Name: William Thomas

13. Birthplace: Oaksville md

MOTHER 14. Maiden name: Mary E Jones

15. Birthplace: Allen md

16. Informant: Miss Lucile Carr

Address: Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 12 1945 (month) (day) (year)

Cemetery or crematory: Public

Location: Salisbury Md

18. Funeral director: James H. Stewart

Address: Salisbury Md

19. 9/12, 1945 (Date rec'd by registrar) Maggie E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 10th 1945 at 4:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 10th 1945, to Sept 10th 1945

and that I last saw h— alive on Sept 10th 1945

Immediate cause of death: Prematurity | DURATION:

Due to:

Due to:

Other conditions: (Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Eldne G. Mausman M. D. or other

Address: Princess Anne MD Date signed: 9.11.45

VS A15

Dr. Lindy

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Final)

CERTIFICATE OF DEATH

09408

Reg. Diat. No. 999

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: md County: Worcester

City or town: Ocean City md (If outside city or town limits, write RURAL and give nearest town)

Street No.: Same as above ✓ (If rural, give LOCATION)

2.(a) If veteran, name war: no

3. (a) FULL NAME: William Stewart

3. (b) Social Security Number: Not known

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	married

6.(b) Name of husband or wife: Sarah Stewart

6.(c) If alive, give age: Don't know years

7. Birth date of deceased (mo., day, yr.): about 1874

8. AGE: Years	Months	Days	If less than one day
71	—	—	...hrs. ...min.

9. Birthplace: (Town, county, and state)

10. Usual occupation: Chief Cook

11. Industry or business: Same as above

FATHER 12. Name: Frank Stewart

13. Birthplace: St. mary's County md

MOTHER 14. Maiden name: Isabell Stewart

15. Birthplace: St. Mary's County md

16. Informant: Isabella Ray

Address: Baltimore

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 22 1945 (month) (day) (year)

Cemetery or crematory: Hamilton

Location: Salisbury md

18. Funeral director: James H. Stewart

Address: Salisbury md

19. 9/22/45 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 19 1945 at 12:45 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-6 1945 to 9-19 1945

and that I last saw h.. alive on 9-19-45 1945

Immediate cause of death	DURATION
Pernicious anemia Marasmatic	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Geo. A. Leahy M. D. or other

Address: Salisbury Md Date signed 9-19-45

09409

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 41 336

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Wicomico

City or town: Delmar

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 86 years

Hospital, institution, or street address where death occurred: 418 East Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Delmar

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 418 East

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Sallie Mary Stayer

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

B.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct 14 1858

8. AGE: Years	Months	Days	If less than one day
86			hrs. min.

9. Birthplace: Pittsville, Maryland (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Home

FATHER 12. Name: Jas. Edward Stayer

13. Birthplace: Wicomico County, Md.

MOTHER 14. Maiden name: Julia Ann Stayer

15. Birthplace: Wicomico County, Md.

16. Informant: Charles Stayer

Address: Delmar, Delaware

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 9 1945 (month) (day) (year)

Cemetery or crematory: Int Olive Methodist

Location: Delmar, Delaware

18. Funeral director: A. S. Grand Co

Address: Delmar, Delaware

19. 9-9-1945 (Date rec'd by registrar) Harry E. Hudson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 6 1945 at 10:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 4 1944 to Sept 6 1945 and that I last saw h[illegible] alive on Sept 6 1945

Immediate cause of death	DURATION
Coma	2 days
Due to Cerebral hemorrhage	3 days
Due to Chronic nephritis & Arteriosclerosis	3 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. N. Tyndall M. D. or other

Address: Salisbury, Md. Date signed: Sept 9 1945

09410

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
P. G. Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 119 Railroad Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Robert Lawrence Taylor

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Beulah Taylor

6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): Dec. 20, 1879

8. AGE: Years	Months	Days	If less than one day
65	9	3	...hrs. ...min.

9. Birthplace: Smyrna, Del. (town, county, and state)

10. Usual occupation: Railroad Baggage Agent

11. Industry or business

FATHER
12. Name: Isaac Taylor
13. Birthplace: Smyrna, Del.

MOTHER
14. Maiden name: Mary Louise Hawlett
15. Birthplace: Smyrna, Del.

16. Informant: Mrs Beulah Taylor

Address: Smyrna, Del.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9 / 27 / 45 (month) (day) (year)

Cemetery or crematory: Glenwood Cemetery

Location: Smyrna, Del

18. Funeral director: The Hill & Johnson Co.

Address: Salisbury, Md.

19. 9/26/45 (Date received by registrar) Harriet E. Johnson (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 23, 1945, at 455a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 1945, to Sept 23 1945
and that I last saw h. alive on Sept 23 1945

Immediate cause of death	DURATION
Acute cardiac failure	
Due to: Uremia Nephrosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Harriet E. Johnson M. D. or other

Address: Salisbury, Md. Date signed: 9-26-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

69411

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (169)

CERTIFICATE OF DEATH

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days
Hospital, institution, or street address where death occurred: The Peninsula General Hospital
How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Wicomico
City or town Delmar (If outside city or town limits, write RURAL and give nearest town)
Street No. 8 Chestnut (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Truitt, George Frank
3.(b) Social Security Number 717-07-9216

4. Sex Male
5. Color or race White
6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Lulu Truitt
6.(c) If alive, give age 56 years
7. Birth date of deceased (mo., day, yr.) July 17-1889
8. AGE: Years 56 Months 1 Days 18 If less than one day ... hrs. ... min.
9. Birthplace Delmar, Delaware (Town, county, and state)
10. Usual occupation Conductor
11. Industry or business Penn. Railroad Co
FATHER 12. Name Silas James Truitt
13. Birthplace Wicomico County, Md.
MOTHER 14. Maiden name Sallie Morris
15. Birthplace Wicomico County, Md.
16. Informant Mrs Lulu Truitt
Address Delmar, Del.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 9 1945 (month) (day) (year)
Cemetery or crematory Mt Olive M E Church
Location Delmar, Delaware
18. Funeral director W. S. Harvel Co
Address Delmar, Delaware
19. 9/9, 1945 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 5 1945, at 3:30 am
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 2 1945, to Sept 5 1945 and that I last saw him alive on Sept 5 1945

Immediate cause of death Brain injury — DURATION
Due to
Due to
Other conditions Traumatic amputation Rt leg. Lacerated scalp (Include pregnancy within 3 months of death)
Major findings of operations as above Date of op. 9-2-45
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accident Date of 9-2-45
Where did injury occur? Salisbury (City or town) Wicomico (County) Md (State)
Injured at home, farm, industry, public place (where?) R.R. tracks
Means of injury Fell off train Injured at work? yes

23. SIGNATURE [illegible] M.D. Deputy Med Examiner M. D. or other
Address Salisbury Md Date signed 9/6/45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93)

09412

CERTIFICATE OF DEATH

★ Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 days
Hospital, institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Salisbury
(If ontside city or town limits, write RURAL and give nearest town)
Street No.: Route #3
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3. (a) FULL NAME: Janie Ella Tull

3. (b) Social Security Number: No

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	a a	married

6.(b) Name of husband or wife: Edward J. Tull
6.(c) If alive, give age: yes Don't know years
7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
about 59			hrs. min.

9. Birthplace: Weldon Worcester Co. Maryland
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: George Brown
13. Birthplace: Weldon Worcester Co. Md

MOTHER
14. Maiden name: Betty Brown
15. Birthplace: Weldon Worcester Co. Md.

16. Informant: Edward Tull
Address: Salisbury, Md. Route # Box 175

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-4-'45 (month) (day) (year)
Cemetery or crematory: Wattsville Cemetary
Location: Wattsville Virginia

18. Funeral director: James F. Stewart
Address: 402 E. Church St. Salisbury Md

19. 9/4/45 (Date rec'd by registrar) Harriet L. Johnson Registrar
Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 1 19 45, at 1:15 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15 19 45 to Sept 1 19 45
and that I last saw her alive on Aug 31 19 45

Immediate cause of death	DURATION
Agranulocytosis	
Arteriosclerotic cardio-	
Due to Vascular heart disease	
Pernicious Anemia	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Salisbury Md Date signed: 9/4/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-a)

09413

CERTIFICATE OF DEATH

★ Reg. Diat. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 Years

Hospital, Institution, or street address where death occurred: 203 W Church St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No. 203 W Church St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William W. Venable

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married

6.(b) Name of husband or wife: Mary R. Venable

6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): Sept 11 1884

8. AGE: Years	Months	Days	If less than one day
60	11	25	...hrs. ...min.

9. Birthplace: Mardela, Wicomico co, Md (Town, county, and state)

10. Usual occupation: Insurance Broke General

11. Industry or business

FATHER 12. Name: Thomas Venables

FATHER 13. Birthplace: Wicomico co Md

MOTHER 14. Maiden name: Mary Westerly

MOTHER 15. Birthplace: Wicomico co, Md

16. Informant: Mrs W W Venable

Address: Salisbury, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/8/45 (month) (day) (year)

Cemetery or crematory: Parsons Cemetery

Location: Salisbury Md

16. Funeral director: The Hill & Johnson co

Address: Salisbury Md

19. 9/8/45 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 6, 1945 at 6 45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-5-45 19... to 10-6-45 19... and that I last saw him alive on 10-6-45 19...

Immediate cause of death	DURATION
Acute Heart Failure.	
Due to: Arterio - Cardio - renal disease.	
Due to: Arteriosclerosis	
Other conditions: Dept Hardening Stone	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Currie T. Hearn M. D. or other

Address: ... Date signed: ...

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (850)

CERTIFICATE OF DEATH

9414

★ Reg. Dist. No. 337

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. (I) MARGIN RESERVED FOR BINDING (T) VS A15

1. PLACE OF DEATH:
County Wicomico
City or town Nanticoke
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Nanticoke
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary L. Wallace

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Col.	Widow

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Mar. 4 - 1881

8. AGE:

Years	Months	Days	If less than one day
64	6	9	..... hrs. ..... min.

9. Birthplace Nanticoke, Md.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Jessie Nutter
13. Birthplace Nanticoke, Md.

MOTHER
14. Maiden name Don't Know
15. Birthplace " "

16. Informant Olivia Wallace
Address Nanticoke, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 19 45 (month) (day) (year)
Cemetery or crematory Cemetery
Location near Jesters store

18. Funeral director Ed Messenger
Address Bivalve Md

19. Sept 19 1945 (Date rec'd by registrar) R. Wolford Waller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 13 1945 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 - 1945 to Sept 13 1945
and that I last saw h..... alive on Sept 13, 45 1945

Immediate cause of death Apoplexy — DURATION 15 days

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE D Allen Fields M. D. or other
Address Nanticoke Md. Date signed 9-15-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09415

Reg. Dist. No. 993

1. PLACE OF DEATH:
County: Talbot
City or town: (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: P. H. Hosp.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Somerset
City or town: Deal Island
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Olin B. Webster

3.(b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Nina Webster
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Unknown
8. AGE: Years: 45 Months: Days: If less than one day: hrs. min.
9. Birthplace: Deal Island Md.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:
FATHER 12. Name: Samuel J. Webster
FATHER 13. Birthplace: Deal Island
MOTHER 14. Maiden name: Alveda Tawes
MOTHER 15. Birthplace: Deal Island Md.
16. Informant: Mrs. Olin B. Webster
Address: Deal Island Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 25-45 (month) (day) (year)
Cemetery or crematory: St. John M.E. Cem.
Location: Deal Island Md.
18. Funeral director: L. B. Webster
Address: Deal Island
19. 9/25/45 (Date rec'd by registrar) Margaret E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 22nd 1945 at 5:15a M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 21, 1945, to Sept 22 1945
and that I last saw h... alive on Sept 22 1945

Immediate cause of death	DURATION
Ch. Myocarditis;	
Due to Bronchial Asthma	hours
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Date signed: 9/25/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Gray

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

9416

Reg. Diat. No. 233

1. PLACE OF DEATH:
County: Wicomico
City or town: Parsonsburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days
Hospital, institution, or street address where death occurred: R.D. #1. Parsonsburg Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Parsonsburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.D. #1.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Mary Elizabeth Winton

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: (Died Sept. 4-1917 at 11. a.m.) 6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 4-1855

8. AGE: Years	Months	Days	If less than one day
90	8	0	hrs. min.

9. Birthplace: R.D. #1. Parsonsburg Md.
(Town, county, and state)
10. Usual occupation: Housework at Home
11. Industry or business:

FATHER
12. Name: John James Parsons
13. Birthplace: R.D. Parsonsburg Md.

MOTHER
14. Maiden name: Milly Ann Parker
15. Birthplace: R.D. Salisbury Md.

16. Informant: Mrs. Millie Pasker
Address: R.D. #1. Parsonsburg Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof Sept. 6-45 (month) (day) (year)
Cemetery or crematory: Mango Church Cem.
Location: Mango, Maryland
18. Funeral director: Holloway & Co. Walter R. Holloway
Address: Salisbury Maryland

19. 9/6 1945 Samuel E. Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 4th 1945 at 7 55 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1945 to Sept 4 1945 and that I last saw her alive on Sept 1 1945

Immediate cause of death	DURATION
Arteriosclerotic Cardiovascular Renal Disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Unsigned M. D. or other
Address: Salisbury Md. Date signed: 9/5/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15